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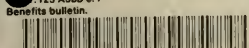
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MARCH 1996

IN THIS EDITION

DEAR STATE EMPLOYEE:

Welcome to another edition of the Benefits Bulletin! A lot of benefit changes have occurred since the last edition. It is time to recap Plan Year 1995, share some information on how to make the best use of existing benefits, and begin preparing for Plan Year 1997.

PLAN YR '95 BROUGHT RECORD-SETTING CLAIMS COSTS INCREASE

This last Plan Year (September 1994 - August 1995), claims costs jumped a record setting 21.6% -- **nearly 6.5 million dollars**. This followed two years of equally precedent-setting flat claims -- creating a three-year claims pattern that resembles our variable weather pattern. Use of more medical services was the primary cause of the '95 surge, although costs per service also rose.

Medical Claims up \$4.2 Million Inpatient (IP) claims costs rose 17% due to an 11% increase in hospital admissions combined with a 5% increase in cost per admission. The average length of hospital stay increased only slightly. Outpatient (OP) claims costs also rose 17% due to a 26% increase in OP hospital services, which was partially offset by a 8% decrease in cost per service and a 12% increase in physician/surgeon services combined with a 5% increase in cost per service.

Not only was there more illness, but more severe illness in PY95. Large cases exceeding \$100,000 more than doubled -- increasing from 8 in PY94 to 18 in PY95. These 10 additional large cases added \$1.5 million. This accounts for 36% of the total \$4.2 million medical increase. See "What Ailed Us" -- next page.

Retail Prescription Drug (Rx) Claims up \$1.65 Million A portion of this increase (\$0.65 million) was caused by a one-time claims overlap. The Plan paid for previous PY94 claims, made under the old paper claims system with substantial year-end run out, on top of PY95 claims that are under a prescription card system with virtually no year-end run out.

Another portion (\$0.4 million) is the result of plan design which unintentionally shifted a larger percentage of total Rx costs from Plan members to the Plan. Deductibles, co-pays and out-of-pocket maximums established for the separate Prescription Card Plan were intended to be cost neutral, but instead increased the Plan's portion of Rx costs from 68.6% in PY94 to 76% in PY95. Members' share correspondingly decreased.

The remaining \$0.6 million in increase is thought to be due to a greater than 30% (story continued on page six)



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MARCH 1996

IN THIS EDITION

- ✓ Plan Year '95 Brought Record-Setting Increase in Claims Costs
- ✓ What Ailed Us
- ✓ Silver Linings -- The Good News
- ✓ Impact of the '95 Claims Surge on Reserve Funds and the Plan's Future
- ✓ Plan Year '96 Bringing Relief -- Medical Claims Trend Down -- So Far
- ✓ What's in the Works for Plan Year '97
- ✓ The Blue Card Program saves time, money for members using out-of-state medical services
- ✓ Q & A-- When Do I Need a Referral and How Do I Get One?
- ✓ For Your Eyes Only - the New Vision Plan Just Got Easier to Use

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WHAT AILED US?

The biggest State Employee Health Plan cost increases were for inpatient treatment of more circulatory/heart problems and more, plus more costly, respiratory problems.

The State Plan's rate of hospital admissions per 1,000 members for heart disease has exceeded that of other Montana Blue Cross/Blue Shield (BC/BS) plans in the past and increased even more (up 22%) in plan year 1995. The rate of heart attack admissions per 1,000 members was 300% above the average reported for other large employer health plans in a nation-wide data base (Med-Stat) recently accessed by BC/BS. Since heart disease is age-related, the State Plan's higher rate may be partially due to a higher average age than for comparison plans. However, in studying an unusually large PY95 claims jump for males age 40-50, their cardiac admissions per 1,000 were found to be 67% above those for the same age-sex group in other BC/BS plans.

Hospital admissions for respiratory care increased 10% in PY95 and costs per admission increased 51% -- primarily due to a few very high-cost cases. The State Plan's hospital admission rate per 1,000 members was over 200% of the Med-Stat rate for: (1) respiratory infections/inflamations (2) pulmonary edema and respiratory failure, (3) chronic obstructive pulmonary disease, and (4) pneumonia/pleurisy. Since each category contains small numbers which may not be significant, this information can only be used to target respiratory disease for further study. Assistance from the State Epidemiologist in assessing the prevalence of and trends in respiratory disease in the state has been requested.

(continued on page six)

Silver Linings

MEDICAL PLAN OPTIONS PROVIDED CHOICE, NOT ADDED EXPENSE

Last Plan Year, when medical plan options first became available, 6% of Plan members chose HMO and 6.5% chose Basic. The remainder stayed on Traditional. This Plan Year, slightly more Plan members took advantage of the options with 8% choosing HMO and 7.5% choosing Basic.

Plan choice does not appear to have contributed to the big PY95 claims increase. The premiums of all plans covered claims, and there was nearly the same claims expense per premium dollar in the more comprehensive HMO as in the Traditional Plan. There was less claims expense per premium dollar in the Basic Plan, suggesting that it attracted the chronically healthy. However, not all its members stayed healthy; several reached the Plan's \$2,000 individual out-of-pocket maximum. Some of these abandoned the Basic Plan this year and others stuck with it expecting to recoup losses in the future with improved health status.

THE PRESCRIPTION DRUG CARD PROGRAM BROUGHT CONVENIENCE (No claims) AND PLAN-MEMBER SAVINGS (including major savings to members on high-cost maintenance prescriptions) -- **DESPITE INCREASES IN PLAN COSTS, DESCRIBED ON PAGE 1.** (See "What's in the Works for Plan Year 97", page 3, for program changes under consideration.)

PREVENTIVE MENTAL HEALTH & COUNSELING BENEFITS WERE ADDED WHILE HOLDING THE LINE ON COSTS.

While total medical claims costs have increased nearly 25% since PY92, Plan costs for psychiatric and chemical dependency services have decreased 14% -- despite some increased benefits. This was achieved through: (1) management (and reduction) of high-cost in-patient services, (2) the addition of an Employee Assistance Program (EAP) to provide expanded low-cost preventive services, and (3) an increase in benefits (from 50% to 75%) for additional non-EAP outpatient services determined by the EAP counselor to be necessary and appropriate. (Please see page 5 for information on the referral process.)

At the close of the EAP's first year of state-wide operation, it had provided services to 1,151 State employees or family members (9.7%). This is higher than average participation in an EAP (7%). Participation was greatest per capita for employees of DNRC, followed by Health and Environmental Sciences, Labor and Industry, and SRS. Nearly 3,500 employees participated in various EAP-led training sessions.

The most frequent problems treated included: depression (23%), marital problems (17%), family problems (17%), another's emotional health (11%), and occupation-related problems (8%). Thirty four percent of EAP cases received referrals for additional non-EAP services. Services referred to included: outpatient counseling (74%), medical assessment (20%) and inpatient treatment (1.5%). ❖

IMPACT OF PY95 CLAIMS SURGE ON RESERVE FUNDS AND THE PLAN'S FUTURE

Plan Year (PY) '95 cost increases were matched by biennium revenue increases, so there was no need to dip into State Employee Health Plan reserve funds. State funding levels for PY95 were established during the 1993 Legislative session, when \$20 per employee per month increases were approved for both years of the biennium ('94 and '95). While the '94 funding increase turned out to be more than adequate in the face of flat PY94 claims, both the PY94 and PY95 funding increases were needed to cover the huge claims surge in PY95.

Since reserve funds were untouched, they are still available for their intended use this biennium. Extra reserves (resulting from flat claims in '93 and '94) are slated for use this biennium to offset reductions in State contribution -- \$10/emp/mo in PY96 with \$5/emp/mo restored for PY97. These State contribution reductions helped provide funding for this biennium's pay plan increase.

Actuarial projections indicate that the extra reserves in combination with the reduced State contributions will be sufficient to cover this biennium's claims costs -- provided those costs do not increase much more than 12% per year. Such a sustained claims increase is possible but not probable. If claims costs do increase that much over the next 2 years, there will be no remaining extra reserves at the end of the biennium to help cover next biennium's projected increases. **That could mean significant premium increases beginning Sept of 1997. We all need to work together now to hold down costs.** ♦

PLAN YEAR 96 BRINGING RELIEF MEDICAL CLAIMS TREND DOWN -- SO FAR

GOOD NEWS: For the first five months of PY96 medical claims costs have leveled off -- running only 1.3% ahead of the same period for PY95. **BAD NEWS:** Dental claims are continuing to surge -- running 15% ahead of last year. Since dental claims consume 10% of plan dollars (compared to 80% for medical), dental increases take a much smaller bite. However, double-digit increases two years in a row hurt, and make dental costs a major focus of attention. Any insights on causes/cures are welcome. **NO NEWS YET:** It is still too early to see a trend for the other 10% of claims --- retail prescription drug claims. While Rx claims are running well ahead of the same months last year, last year's early months had unusually low claims due to start up of the new Prescription Card Plan. ♦

In the Works for Plan Year 97

▀ A once per life-time **DENTAL SEALANT** benefit for molars of children under age 16 will be available.

▀ The option of **AUTOMATIC BANK DEPOSIT** of flexible spending account reimbursements is expected to be available.

▀ The option of having medical claim amounts you are responsible to pay automatically sent by the claims processor (BCBS) to the Flexible Spending Account program administrator for payment is being explored and may be available later in the year.

▀ There may be a **DEDUCTIBLE, CO-PAY, OR OUT-OF-POCKET MAX. ADJUSTMENT FOR THE PRESCRIPTION DRUG BENEFIT** to restore the same cost sharing between the plan and plan members as existed before the card program was implemented (See article on page 1.)

▀ There may be **NEW DEFERRED COMPENSATION OPTIONS**. Current contracts for investment and third party administration services expire December 31, 1996. The William Mercer Consulting firm has been retained to review the State Deferred Compensation program, make recommendations on improvements, and assist in rebidding contracts. Any significant proposed changes will be distributed to Deferred Compensation members for review and input before adoption.

ANNUAL CHANGE

The Annual Benefits Change Period is coming. This is the one time per benefit year you can make insurance changes. Watch for an information packet around the end of May and first part of June.

STRESSED?

VRI is offering **FREE** seminars on **Coping Skills** in the following areas:
Billings - March 19
Bozeman - March 20
Boulder - March 19
Butte - March 21
Deer Lodge - March 14
Great Falls - March 14
Helena - March 13
Kalispell - March 14
Missoula - March 20
You will learn how to manage stress, communicate effectively, and resolve conflicts at this seminar. Call

Sue Robb at 1-(406) 721-0291 for more information. Registration is not required. VRI is the Employee Assistance Program provider for the State. ♦

FOR YOUR EYES ONLY--THE NEW VISION PLAN JUST GOT EASIER TO USE

The new vision plan was very well-received with 4,349 of our 13,488 certificate holders (employees/retirees) electing the optional hardware coverage.



It is also well-used. Within the first 4 months, benefits have been provided for 1,580 exams and for 2,370 exams and pairs of glasses or contact lens. Vision Service Plan administrators report that 89% of these services were provided by VSP doctors.

Starting February 1, 1996, obtaining benefits through VSP member doctors got easier! **Plan members may now visit VSP member providers without first obtaining the authorized benefit form.**

Simply contact a VSP member provider and make an appointment. When calling for the appointment, identify yourself as a State Plan and VSP member and provide your identification number (your social security number). The VSP member doctor will obtain the necessary authorization and information about your eligibility and coverage from VSP.

When using a non-VSP doctor, you still need to obtain a claim form from the Employee Benefits Bureau, your agency payroll personnel or from VSP by calling 1-800-622-7444. Complete the form and send it in to VSP for the appropriate reimbursement. ♦

New VSP Doctors

Jim Phelan, Optometrist
121 N. Last Chance Gulch #A
Helena, MT 59601
(406) 442-4620

Robert D. Lunde & Lynn Carlo,
Optometrists
811 Pleasant St.
Miles City, MT 59301
(406) 232-7426

Robert Kautz, Optometrist
1212 Grand Ave.
Billings, MT 59102
(406) 248-1676

David Cramer, Optometrist
726 Kensington Ave.
Missoula, MT 59801
(406) 549-9413

Donald Toucher, Optometrist
200 US Hwy 2 East
Wolf Point, MT 59201
(406) 653-2001

Marta King, MD
2600 Wilson St.
Miles City, MT 59301
(406) 233-3937

Remove the following Non-VSP Preferred Provider from your list:

Charles Marledge, M.D.
1600 Poly Dr.
Billings, MT 59101
(406) 252-6608

THE BLUE CARD PROGRAM CAN SAVE YOU TIME, MONEY ON OUT-OF-STATE MEDICAL SERVICES

Presenting a Blue Cross/Blue Shield insurance card for out-of-state medical services can now do more than provide evidence of insurance. If you use a doctor or hospital who is participating in provider agreements with a local Blue Cross and Blue Shield Plan, you may receive the benefit of those agreements.

When receiving medical services from a BC/BS participating provider in another state, simply present your BC/BS insurance card **and leave claims processing to them.** They will file a claim with the local BC/BS plan, who will electronically send it to BC/BS of Montana. BC/BS of Montana will send back information on the level of benefits payable under your plan. The local BC/BS will then apply any negotiated discounts and pay the provider.

The biggest benefit can be protection against charges in excess of plan allowances. If the provider is part of an agreement to accept plan allowances, you won't have to worry about unallowed charges. ♦

Question & Answer:



Q: When do I need a referral before seeing a specialist? How do I get one?

A: If you belong to the HMO, you need a referral from your HMO Personal Care Physician (PCP) for most care from another provider. If you would like to receive enhanced outpatient psychiatric or chemical dependency benefits, you need a referral from the Employee Assistance Program (EAP) or, if on HMO, from your Personal Care Physician.

REFERRALS FROM YOUR PCP

If you belong to the HMO, your Personal Care Physician provides primary care and refers you to other providers for any specialty care you need. Only those services of other providers for which you have been referred are covered. To meet the referral requirement, take the following steps:

1. See or call your PCP for a referral **before** seeing another provider for any medical services (including emergency care, psychiatric care, and chemical dependency care), with the following exceptions:

Dental care

Vision care

Maternity care (after pregnancy has been diagnosed by PCP)

Life-threatening emergency care (such as shock, unconsciousness, uncontrollable bleeding) which prevents an advance call to your PCP.

Instead, call HMO MT within 48 hours.

Emergency or urgent care while traveling outside your PCP's service area. *Instead, call HMO MT within 48 hours.*

2. To prevent any misunderstandings, you may want to ask for a copy of the referral and note:

- To whom are you being referred;
- The services for which you are being referred;
- The dates of services for which the referral is written.

Only the type of services and number of visits or period of time indicated are covered by the referral.

3. Check your plan. A referral is not a guarantee of benefits. Services which fall under a plan exclusion are not covered regardless of a PCP referral. ❖

REFERRALS FROM YOUR EAP

Outpatient psychiatric and chemical dependency services that are covered by the State Plan are eligible for enhanced benefits if you obtain an EAP counselor's referral or, for HMO members, a PCP's referral. (Enhanced benefits are 75% of the allowable charges - after deductible -- up to a maximum of \$2,250 per year; standard benefits are 50% of allowable charges - after deductible up to a maximum of \$1,500 per year).

To obtain an EAP referral, take the following steps:

1. **First**, make an appointment with an EAP counselor for assessment and counseling.
2. If your EAP counselor determines you need additional treatment beyond that available through the EAP, the counselor, in cooperation with you, will develop a treatment plan/referral which includes an appropriate level and provider of care.
3. **Then**, make an appointment with the outside provider and receive the services indicated in the treatment plan. **Retroactive referrals (after you have received the services) are not available.**
4. You may prevent any misunderstandings by obtaining a copy of the treatment plan/referral and noting those items described in step two for a PCP referral.
5. Remember, a referral is not a guarantee of benefits. Services which fall under plan exclusions are not covered, regardless of an EAP referral. Check your plan. ❖

CLAIMS UP (from page one)

increase in out-patient Rx usage. That cannot be verified due to unreliable PY94 out-patient usage figures, but in-patient Rx usage increased 44%. Such a large increase in prescriptions could not all be offset by lower contract prices per prescription.

Dental Claims up over \$0.5 Million Dental costs increased 19% -- a combination of a greater than 10% increase in number of services and a 8% increase in cost per service. This was the most extreme change, since the highest increase in the previous eight years was under 9% with an average of 5.6%. Usage of all types of dental services increased. The biggest increases in cost per service were for diagnostic services - exams/x-rays - (up 12.6%); oral surgery (up 21%); and endodontics (up 18%). ♦

WHAT AILED US (from page two)

What about cancer? Although Blue Cross and Blue Shield does not report admission rates for cancer diagnoses as a group, 8 of the State Plan's 18 large cases, over \$100,000 in PY95 involved cancer diagnoses. Malignancies of various types were the most common ailment in our most severe cases. Future health promotion efforts, including health screenings, will focus on these identified health risks. ♦

1996 HEALTH SCREENINGS --

Every other year, the State Plan offers **FREE** "health screenings" to employees and low-cost screenings to spouses who are members of the Plan. The screenings are designed to help you identify and reduce health risks **you can control** before they result in serious illness and include -

- ☐ A health risk appraisal (questionnaire)
- ☐ Glucose, cholesterol & triglycerides test
- ☐ Blood pressure check
- ☐ Waist-to-hip body mass assessment
- ☐ Strength and flexibility assessment.

Helena area retirees and Plan members in Butte, Dillon, Deer Lodge, Warm Springs, and Anaconda will be screened in April. Watch for your announcement. ♦

Personal Financial Planning Seminars



The Public Employees' Retirement Board has contracted with ICMA Retirement Corp. to conduct a series of evening seminars for public employees interested in learning about financial planning strategies. Thirteen seminars are scheduled during March through June in Billings, Miles City, Helena, Bozeman, Kalispell, Missoula, Butte, Dillon, Great Falls, Havre and Glasgow. There will also be one seminar on Personal Investment Strategies on April 18 in Helena. Information about specific seminar sites and registration information will be distributed by employers in the near future. A second series is planned for next fiscal year. ♦

The Department of Administration is dedicated to providing the best possible benefits plans for the revenues and statutory authority provided. We want to hear your preferences and suggestions.

If you have a question, concern or a personal experience with saving unnecessary health care cost you would like to share, please send it to:

Benefits Bulletin
Employee Benefits Bureau
PO Box 200127
Helena, MT 59620-0127

Each edition of the Benefits Bulletin will attempt to answer the most commonly asked questions and pass along tips from our members on how to be a wise health care consumer.

Alternate accessible formats of this document are available. Call (406) 444-3871 or TDD relay 1-800-253-4091.

